Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: ACTIVE BEHAVIORAL HEALTH 2420 EAST RANDOL MILL ROAD ARLINGTON TEXAS 76011-6335	MFDR Tracking #: M4-05-9868-01 DWC Cla Injured Ei
Respondent Name and Box #: Zurich American Insurance Company c/o Flahive, Ogden & Latson Box 19	Date of In Employer Insurance Car

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCU

Requestor's Position Summary states in part "...DOS 8/5/04 and DOS 2/1/05: Provider followed fee guidelines for preauthorized services. DOS 9/14/04: NO EOB provided by carrier for preauthorized service..."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - **$371.42**
3. CMS 1500(s)
4. EOB(s)
5. Preauthorization letters

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary states in part "...Carrier moves to dismiss DOS 09/14/04 because a provider must make a timely and valid request for reconsideration before requesting medical dispute resolution...As to the other DOS, carrier paid IAW all applicable rules and procedures..."

Principle Documentation:

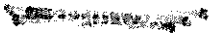
1. Response to DWC 60

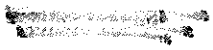
PART IV: SUMMARY OF FINDINGS

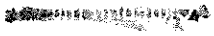
Eligible Dates of Service (DOS)	CPT Code(s) and Calculations	Denial Codes	Part V Reference	Ordered Amount
08/05/04	90901	*	2,3,4,5	$00.00
09/14/04	90901	No EOB	1,2,3,4,6	$53.06
02/01/05	90901	*	2,3,4,7	$00.29
Total Due:				**$53.35**

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.







1. Neither party provided EOB's for this services. The Requestor submitted convincing evidence of carrier receipt for request for EOB's in accordance with 133.307 (e)(2)(B). These services will be reviewed in accordance with Rule 134.202.

2. Per Rule 134.202(b) the maximum reimbursement amount is determined by locality. Per Box 32 of the form CMS-1500 services were performed in Dallas County zip code 75228.

3. These services were denied by the Respondent with reason code "*—CHARGE IN EXCESS OF UNIT VAL ALLOW."

4. CPT code 90901 is defined as biofeedback by any modality. This is not a timed procedure.

5. For DOS 08/05/04: The MFG MAR for CPT code 90901 in Dallas County is $53.06. The Requestor billed $990.00. The Respondent paid $53.06; therefore, additional reimbursement is not recommended.

6. For DOS 09/14/04: The MFG MAR for CPT code 90901 in Dallas County is $53.06. The Requestor billed $990.00. The Respondent paid $00.00; therefore, reimbursement is recommended.

7. For DOS 02/1/05: The MFG MAR for CPT code 90901 in Dallas County is $53.35. The Requestor billed $990.00. The Respondent paid $53.06; therefore, additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §133.307, §134.1, §134.202
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Section §413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$53.35 plus applicable accrued interest** per Division Rule 134.130 due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	10/01/07 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.